PROPERTY & CASUALTY INSURERS

COMPANY NAME: _____ **NAIC Company Code:** _____
Contact: _____ **Telephone:** _____
REQUIRED FILINGS IN THE STATE OF: MONTANA **Filings Made During the Year 2006**

(1) Check-list	(2) Line #	(3) REQUIRED FILINGS FOR THE ABOVE STATE	(4) NUMBER OF COPIES* Domestic State	Domestic NAIC	Foreign State	(5) DUE DATE	(6) FORM SOURCE**	(7) APPLICABLE NOTES
		I. NAIC FINANCIAL STATEMENTS						
	1	Annual Statement (8 ½" x 14")	1	1	xxx	3/1	NAIC	A thru N
	1.1	Printed Investment Schedule detail (Pages E01-E25)	1	1	xxx	3/1	NAIC	A thru N
	2	Quarterly Financial Statement (8 ½" x 14")	1	1	xxx	5/15, 8/15, 11/15	NAIC	A thru N
	3	Protected Cell Annual Statement	0	0	xxx	3/1	NAIC	A thru N
	4	Combined Annual Statement (8 ½" x 14")	0	1	0	5/1	NAIC	A thru N
		II. NAIC SUPPLEMENTS						
	10	Accident & Health Policy Experience Exhibit	1	1	xxx	4/1	NAIC	A thru N
	11	Combined Insurance Expense Exhibit	1	1	xxx	5/1	NAIC	A thru N
	12	Credit Insurance Experience Exhibit	1	1	xxx	4/1	NAIC	A thru N
	13	Financial Guaranty Insurance Exhibit	1	1	xxx	3/1	NAIC	A thru N
	14	Investment Risk Interrogatories	1	1	xxx	4/1	NAIC	A thru N
	15	Insurance Expense Exhibit	1	1	xxx	4/1	NAIC	A thru N
	16	Long Term Care Experience Reporting Forms	1	1	xxx	4/1	NAIC	A thru N
	17	Management Discussion & Analysis	1	1	xxx	4/1	Company	A thru N
	18	Medicare Supplement Insurance Experience Exhibit	1	1	xxx	3/1	NAIC	A thru N
	19	Premiums Attributed to Protected Cells Exhibit	1	1	xxx	3/1	NAIC	A thru N
	20	Reinsurance Attestation Supplement	1	1	xxx	3/1	Company	A thru N
	21	Reinsurance Summary Supplemental	1	1	xxx	3/1	NAIC	A thru N
	22	Risk-Based Capital Report	1	1	xxx	3/1	NAIC	A thru N
	23	Schedule SIS	1	N/A	N/A	3/1	NAIC	A thru N
	24	Statement of Actuarial Opinion	1	1	xxx	3/1	Company	A thru N, Y
	25	Actuarial Opinion Summary	0	N/A	0	3/15	Company	A thru N
	26	Supplement A to Schedule T	1	1	xxx	3/1, 5/15, 8/15, 11/15	NAIC	A thru N
	27	Supplemental Compensation Exhibit	1	N/A	N/A	3/1	NAIC	A thru N
	28	Trusteed Surplus Statement	1	1	xxx	3/1, 5/15, 8/15, 11/15	NAIC	A thru N
		III. ELECTRONIC FILING REQUIREMENTS						
	30	Annual Statement Electronic Filing	xxx	1	xxx	3/1	NAIC	
	31	March .PDF Filing	xxx	1	xxx	3/1	NAIC	
	32	Risk-Based Capital Electronic Filing	xxx	1	N/A	3/1	NAIC	
	33	Combined Annual Statement Electronic Filing	xxx	1	xxx	5/1	NAIC	
	34	Combined Annual Statement .PDF Filing	xxx	1	xxx	5/1	NAIC	
	35	Supplemental Electronic Filing	xxx	1	xxx	4/1	NAIC	
	36	Supplemental .PDF Filing	xxx	1	xxx	4/1	NAIC	
	37	Quarterly Electronic Filing	xxx	1	xxx	5/15, 8/15, 11/15	NAIC	
	38	Quarterly .PDF Filing	xxx	1	xxx	5/15, 8/15, 11/15	NAIC	
	39	June .PDF Filing	xxx	1	xxx	6/1	NAIC	
		IV. AUDITED FINANCIAL STATEMENTS						
	51	Accountants Letter of Qualifications	1	N/A	N/A		Company	A, B, E, I, J, K, X
	52	Audited Financial Statements	1	1	xxx	6/1	Company	A, B, E, I, J, K, X
	53	Audited Financial Statements Exemption Affidavit	1	N/A	N/A		Company	A, B, E, I, J, K, X
	54	Independent CPA	1	N/A	N/A		Company	A, B, E, I, J, K, X
	55	Notification of Adverse Financial Condition	1	N/A	N/A		Company	A, B, E, I, J, K, X
	56	Report of Significant Deficiencies in Internal Controls	1	N/A	N/A		Company	A, B, E, I, J, K, X
	57	Request for Exemption to File	1	N/A	N/A		Company	A, B, E, I, J, K, X
	58	Request to File Consolidated Audited Annual Statements	1	N/A	N/A		Company	A, B, E, I, J, K, X
		V. STATE REQUIRED FILINGS						
	101	Certificate of Compliance	0	0	1	3/1	Domicile	A, B, E, O
	102	Certificate of Deposit	0	0	1	3/1	Domicile	A, B, E, P
	103	Copy of Annual Statement Montana State Page w/Tax Report	1	0	1	3/1	Company	A, B, E
	104	Filings Checklist Page 1 (with Column 1 completed)	1	1	1	3/1	State	A, B, E
	105	Genetics Program Charge Form (SAI 26)	1	0	1	3/1	State	A, B, E, N, Q
	106	Holding Company Statement	1	0	0	4/30	State	A, B, E
	107	Insurance Department Financial Examination Report	0	0	1	When available	Domicile	A, B, E, R
	108	Montana Comprehensive Health Association (MCHA) Survey	1	0	1	3/1	State	A, B, E, N, S
	109	Montana Medical Malpractice Professional Liability Experience	1	0	1	3/1	State	A, B, E, N, T
	110	Montana Premium Tax Report & Remittance (SAI 28)	1	0	1	3/1	State	A thru F
	111	Quarterly Premium Tax Forms (SAI 23)	1	0	1	4/15, 6/15, 9/15, 12/15	State	A, B, D, E, F, U
	112	Report of Insured Montana Residents	1	0	1	3/1	State	A, B, E, V
	113	Small Employer Group Activity Report (SEHRP-04)	1	0	1	3/1	State	A, B, E, W
	114	State Filing Fees	1	0	1	3/1	State	A, B, C, E, F
	115	Signed Jurat	0	xxx	1	3/1	NAIC	A, B, E, L

***If XXX appears in this column, this state does not require this filing, if hard copy is filed with the state of domicile and the NAIC and if the data is filed electronically with the NAIC. If N/A appears in this column, the filing is required with the domiciliary state.**
****If Form Source is NAIC, the form should be obtained from the appropriate vendor.**

	NOTES AND INSTRUCTIONS (A-K APPLY TO ALL FILINGS)
A	**Required Filings Contact Person**: Montana Insurance Department, Examinations Bureau 406-444-2040 or Fax 406-444-3497 E-mail Addresses: DeeAnn Glowacki at dglowacki@mt.gov; Cheryl Donovan at cdonovan@mt.gov; Tim Morris at tmorris@mt.gov; Richard Kain at rkain@mt.gov
B	**Mailing Address**: Montana Insurance Department Examinations Bureau 840 Helena Avenue Helena, MT 59601
C	**Mailing Address for Filing Fees**: Mailing address is same as above. The fee of $1900 should be included with the premium tax form and payment due March 1. If due date falls on weekend or holiday, deadline is extended to next business day.
D	**Mailing Address for Premium Tax Payments**: Same as B.
E	**Delivery Instructions**: Make checks payable to "Commissioner of Insurance, State of Montana." All filings must be postmarked no later than the indicated due date. If due date falls on weekend or holiday, deadline is extended to next business day. The premium tax return (SAI 28) with attachments and any payment is due March 1. A copy of the annual statement Montana State Page should be attached to the tax return. If possible, the tax return should be printed on yellow paper. If you are completing tax returns for several affiliated companies within a group, and some or all of the companies have a net amount due, please attach a separate check for each company. DO NOT combine amounts for groups of companies. Note that the tax return requires all companies remit a check for $1900 in payment of all Montana filing and renewal fees, plus additional premium taxes due. In the event your company has overpaid premium taxes in 2005, and the overpayment credit is subsequently confirmed by this Department, the credit must be applied toward 2006 quarterly premium tax prepayments. Montana Administrative Rules pertaining to tax payments: 6.6.2706 Adjustments (1) Over the course of the calendar year, the insurer shall make the periodic payment in the amounts specified by ARM 6.6.2704. Any adjustments in the amounts paid must be made in conjunction with the filing of the report and payment of tax on March 1 of each year. Any credit must be carried forward and used to offset future periodic payments. 6.6.2704 Methods of Calculation (1) Every insurer shall pay its quarterly premium tax obligation as follows: (a) pay an amount equal to 100% of its prior calendar year premium tax in four equal payments, or (b) pay an amount equal to 90% of current year premium tax obligation, as calculated pursuant to 33-2-705(2), MCA, in four equal payments. 6.6.2707 Cessation of Business (1) If an insurer, on a form approved by the commissioner and under oath, notifies the commissioner that it is no longer writing new or renewing existing insurance policies of any type in the state, the commissioner may waive the periodic payment requirements established in these rules. 6.6.2708 Application of Refund (1) If an insurer, on a form approved by the commissioner and under oath, notifies the commissioner that it is entitled to a refund, the commissioner may authorize a refund. An insurer is not entitled to receive interest on the refund.
F	**Late Filings**: The commissioner may impose a fine [Sections 33-2-701(7) and 33-2-705(6), MCA] if filings are not made in time provided, or suspend or revoke the certificate of authority of any insurer that fails to pay taxes as required. [Section 33-2-705(5), MCA]

G	**Original Signatures**: Domestic insurers must submit an annual statement with original signatures on the Jurat page. Foreign insurers may use facsimile signatures or reproductions of original signatures on Signed Jurat page.
H	**Signature/Notarization/Certification**: Domestic insurers' annual statement must be verified by the oath of the insurer's president or vice-president and secretary or, if a reciprocal insurer, by the oath of the attorney-in-fact or its like officers if a corporation.
I	**Amended Filings**: See NAIC Annual Statement Instructions for guidance on amended filings.
J	**Exceptions from normal filings**: Companies must submit a written request for an exemption or extension to the Department of Insurance. Foreign companies must include a copy of any exemption or extension received by its state of domicile to receive such from Montana.
K	**Bar Codes (State or NAIC)**: Montana is not currently using Bar Codes.
L	**Signed Jurat**: Montana now waives foreign insurers from filing printed annual statements and NAIC supplements if filed with the state of domicile and the NAIC, and filed electronically with the NAIC. The Signed Jurat page is due March 1. Facsimile signatures or reproductions of original signatures may be used. In the event that any financial data is refiled or amended, a newly completed Jurat page is required.
M	**NONE Filings**: See NAIC Annual Statement Instructions. Exceptions are noted in the instructions.
N	**Filings new, discontinued or modified materially since last year**: NEW: Actuarial Opinion Summary as required by the Annual Statement Instructions for the Actuarial Opinion Reinsurance Attestation Supplement and Reinsurance Summary Supplemental Montana Medical Malpractice Professional Liability Experience Report. See Note T. Genetics Program Charge is now $1.00. See Note Q. MCHA Survey is now due March 1. See Note S.
O	**Certificate of Compliance**: Each foreign insurer shall file a Certificate of Compliance issued by the public official having supervision of insurance in the insurer's state of domicile. It shall certify that the company is duly organized and authorized to transact insurance therein and the kinds of insurance it is authorized to transact. Due March 1.
P	**Certificate of Deposit**: Each foreign insurer shall file a Certificate of Deposit issued by the official having supervision of insurance in the insurer's state of domicile. It shall certify the amount and the composition of the deposit maintained by the insurer in another state for the protection of all policyholders. Due March 1.
Q	**Genetics Program Charge Form** (SAI 26): Pursuant to Section 33-2-712, MCA, an insurer is required to pay to the Commissioner of Insurance $1.00 per Montana resident insured under any individual or group disability (health) insurance policy in effect on February 1, 2006. Any payment due for Genetics Program Charges should be made by attaching a SEPARATE CHECK FOR THE AMOUNT DUE. A Genetics Program Charge Form is enclosed in your packet if your company is licensed to transact Disability (Health) insurance in Montana. Due March 1.
R	**Insurance Department Financial Examination Report**: A copy of the domicile state examination report of foreign insurers is required to be filed with this Department as soon as the report is filed by the domicile state as a public document. An electronic filing is accepted in lieu of hard copy filing if filed electronically with the NAIC.

S	**Montana Comprehensive Health Association (MCHA) Survey**: This report is enclosed if your company is licensed to transact Disability (Health) insurance in Montana. Form has been revised to include association group – individual market type premiums and to include Medicare Advantage and Medicare Part D Plans as exclusions. Due March 1.
T	**Montana Medical Malpractice Professional Liability Experience Report:** New legislation now requires this report from all Property/Casualty insurers writing medical malpractice professional liability insurance in Montana [Section 33-23-310, MCA]. Due March 1.
U	**Quarterly Premium Tax Forms and Instructions** (SAI 23): Pursuant to Section 33-2-705(7) MCA, and Montana Administrative Rules 6.6.2701 – 6.6.2709, an insurer operating in Montana is required to remit its 2006 premium taxes on a quarterly basis on or before the 15th day of the following months: April, June, September, and December. 6.6.2704 Methods of Calculation (1) Every insurer shall pay its quarterly premium tax obligation as follows: (a) pay an amount equal to 100% of its prior calendar year premium tax in four equal payments, or (b) pay an amount equal to 90% of current year premium tax obligation, as calculated pursuant to 33-2-705(2), MCA, in four equal payments. 6.6.2707 Cessation of Business (1) If an insurer, on a form approved by the commissioner and under oath, notifies the commissioner that it is no longer writing new or renewing existing insurance policies of any type in the state, the commissioner may waive the periodic payment requirements established in these rules. Include with the 2006 quarterly premium tax remittances a completed voucher form SAI 22. Each insurer is required to file the quarterly prepayment forms with the Department even if no payment is due. If no direct business will be written in Montana during 2006, return all four voucher forms marked "zero" with the April 15 filing. The quarterly premium tax prepayment forms contain line-by-line calculation information, along with additional instructions on the reverse of the quarterly forms.
V	**Report of Insured Montana Residents**: This report is enclosed if your company is licensed to transact Disability (Health) insurance in Montana. Due March 1.
W	**Small Employer Group Activity Report** (SEHRP-03): This report is enclosed if your company is licensed to transact Disability (Health) insurance in Montana. Due March 1.
X	**Audited Financial Statements**: FOREIGN INSURERS ONLY – Please refrain from submitting the Audited Financial Statements to this office until further notice.
Y	**Statement of Actuarial Opinion**: Domestic insurers are required to submit the actuarial opinion, including a copy of the actuarial report supporting the actuarial opinion together with related actuarial work papers. Due March 1.

General Instructions
For Companies to Use Checklist

Please Note: **This state's instructions for companies to file with the NAIC are included in this Checklist. The NAIC will send mailing labels, and other information, to all companies but will not be sending their own checklist this year.**

Electronic filing is intended to include filing via the Internet or filing via diskette with the NAIC. Companies that file with the NAIC via the Internet are not required to submit diskettes to the NAIC.

Column (1) **(Checklist)** Companies may use the checklist to submit to a state, if the state requests it. Companies should copy the checklist and place an "x" in this column when mailing information to the state.

Column (2) **(Line #)** Line # refers to a standard filing number used for easy reference. This line number may change from year to year.

Column (3) **(Required Filings)** Name of item or form to be filed.

The ***Annual Statement Electronic Filing*** includes the annual statement data and all supplements due March 1, per the *Annual Statement Instructions*. This includes all detail investment schedules and other supplements for which the *Annual Statement Instructions* exempt printed detail.

The ***March .PDF Filing*** is the .pdf file for annual statement data, detail for investment schedules and supplements due March 1.

The ***Risk-Based Capital Electronic Filing*** includes all risk-based capital data.

The ***Supplemental Electronic Filing*** includes all supplements due April 1, per the *Annual Statement Instructions.*

The ***Supplemental .PDF Filing*** is the .pdf file for all supplemental schedules and exhibits due April 1.

The ***Quarterly Statement Electronic Filing*** includes the complete quarterly statement data.

The ***Quarterly Statement .PDF Filing*** is the .pdf file for quarterly statement data.

The ***Combined Annual Statement Electronic Filing*** includes the required pages of the combined annual statement and the combined Insurance Expense Exhibit.

The ***Combined Annual Statement .PDF Filing*** is the .pdf file for the Combined annual statement data and the combined Insurance Expense Exhibit.

The ***June .PDF Filing*** is the .pdf file for the Audited Financial Statements.

Column (4) **(Number of Copies)** Indicates the number of copies that each foreign or domestic company is required to file for each type of form. The Blanks (E) Task Force modified the 1999 *Annual Statement Instructions* to waive paper filings of certain NAIC supplements and certain investment schedule detail. if such investment schedule data is available to the states via the NAIC database. The checklists reflect this action taken by the Blanks (EX4) Task Force. XXX appears in the "Number of Copies" "Foreign" column for the appropriate schedules and exhibits. **Some states have chosen to waive printed quarterly and annual statements from their foreign insurers and to rely upon the NAIC database for these filings. This waiver could include supplemental annual statement filings. The XXX in this column might signify that the state has waived the paper filing of the annual statement and all supplements.**

Column (5) **(Due Date)** Indicates the date on which the company must file the form.

Column (6) **(Form Source)** This column contains one of four words: "NAIC," "State," "Company," or "Domicile." If this column contains "NAIC," the company must obtain the forms from the appropriate vendor. If this column contains "State," the state will provide the forms with the filing instructions. If this column contains "Company," the company, or its representative (e.g., its CPA firm), is expected to provide the form based upon the appropriate state instructions or the NAIC *Annual Statement Instructions.* If this column contains "Domicile," the company's state of domicile should provide the document.

Column (7) **(Applicable Notes)** This column contains references to the Notes to the Instructions that apply to each item listed on the checklist. The company should carefully read these notes before submitting a filing.

MONTANA INSURANCE DEPARTMENT
840 HELENA AVENUE
HELENA, MONTANA 59601
(406) 444-2040

2005 ANNUAL PREMIUM TAX STATEMENT FIRE COMPANIES CASUALTY COMPANIES

Insurer Name	**NAIC Number**

Mailing Address	**City**	**State**	**Zip Code**

State of Domicile	**Tax & Fee Contact Person**	**Contact Person Telephone Number**

Administrative Office Fax Number	**Toll Free Telephone Number for Policyholder Inquiries**

SCHEDULE A - PREMIUM TAX CALCULATION

1. Total Direct premium income (Ann. Stmt: P/C-pg 20, ln 34, col 1; Health-pg 30, ln 12 & 14, col 1; Title-pg 52, ln 27, col 3, 4, 5) $_____ [1]
2. Finance and service charges (Ann. Stmt.: P/C-page 20 footnote a) $_____ [2]
3. TOTAL PREMIUMS COLLECTED (add lines 1 and 2) $_____ [3]
4. Dividends refunded or credited to policyholders (Ann. Stmt.: P/C-page 20, line 34, column 3) $_____ [4]
5. NET PREMIUMS per 33-2-705(1), MCA (line 3 less line 4) $_____ [5]
6. PREMIUM TAX per 33-2-705(2), MCA (2.75% of line 5) $_____ [6]

SCHEDULE B - FIRE INSURANCE PREMIUM TAX CALCULATION

Taxes are due and payable on the fire portion of the net direct premiums on risks resident, situated or located in Montana. Dollar amount and percentages must be used so that the calculation can be traced to the annual statement. References to rating organizations are not acceptable. Amounts in column IV are to be derived by multiplying amounts in column II by percentages in column III.

	I **LINE OF BUSINESS**	II **ANNUAL STMT. PG. 20, COL. 1 DIRECT PREMIUM**	III **% ALLOCATION OF FIRE RISK**	IV **DOLLAR AMOUNT OF FIRE PREMIUMS**	
7.	Fire		100%		[7]
8.	Allied Lines				[8]
9.	Farmowners Multi Peril				[9]
10.	Homeowners Multi Peril				[10]
11.	Commercial Multi Peril				[11]
12.	Ocean Marine				[12]
13.	Inland Marine				[13]
14.	Other Private Passenger Auto Liability				[14]
15.	Other Commercial Auto Liability				[15]
16.	Private Passenger Auto Physical Damage				[16]
17.	Commercial Auto Physical Damage				[17]
18.	Aircraft				[18]
19.	Burglary & Theft				[19]
20.	Boiler & Machinery				[20]

21. Total Net Fire Premiums (add lines 7 thru 20, column IV) $_____ [21]
22. Tax on Fire Insurance Premiums per 50-3-109(1), MCA **(2.5% of line 21)** $_____ [22]

CO. NAME _____ NAIC # _____ STATE OF DOMICILE_____

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SCHEDULE C -- CALCULATION OF TOTAL TAXES AND FEES

23.	Premium Tax (from line 6)	$_____	[23]
24.	Retaliatory Amount per 33-2-709, MCA (from Schedule E, Line 3 or 4)	$_____	[24]
25.	TOTAL (Add lines 23 and 24)	$_____	[25]
26.	Montana premium tax quarterly pre-payments	$_____	[26]
27.	Overpayments of prior year premium taxes (as confirmed by credit letter)	$_____	[27]
28.	20% of "Class B" Certificates of Contribution from the Montana Life & Health Insurance Guaranty Assoc. issued in the years 2000-2004, per 33-10-230, MCA (ATTACH CERTIFICATES OF CONTRIBUTION)	$_____	[28]
29.	100% of Assessments paid in 2005 to the Montana Comprehensive Health Association, excluding HIPAA Plan Liability Assessments per 33-22-1513(6), MCA (PROOF OF PAYMENT AND ASSESSMENT LETTER MUST BE ATTACHED)	$_____	[29]
30.	Empowerment Zone New Employees – tax credit (include copy of certification from Montana Department of Labor and Industry).	$_____	[30]
31.	Gross Deductions (add lines 28, 29 and 30)	$_____	[31]
32.	Allowable Deductions (enter the smaller of line 23 or line 31)	$_____	[32]
33.	Total payments and credits (add lines 26, 27 and 32)	$_____	[33]
34.	If line 25 is larger than line 33, DIFFERENCE is **TAX DUE**	$_____	[34]
35.	**Fire Insurance Premium Tax** (from Schedule B line 22)	$_____	[35]
36.	**COMPANIES MUST REMIT $1,900 IN PAYMENT OF ALL MONTANA FEES**	$ $1900.00	[36]
37.	**TOTAL REMITTANCE** (add lines 34, 35 and 36)	$_____	[37]
38.	If line 33 is larger than line 25, DIFFERENCE is **ANNUAL TAX OVERPAYMENT**	$_____	[38]

OVERPAYMENT must be carried forward and used to offset future periodic payments.

The above statement, and attached Schedules D and E, are true and correct reports of premiums collected and of authorized deductions pertaining to business transacted in Montana in the past calendar year and are in accordance with the requirements of the applicable statutes.

Title of Officer	Name of Officer (Type or print)
Date	Signature of Officer

TAX RETURN CHECKLIST Did You Remember to:

1. _____ Attach Annual Statement Montana State Page?
2. _____ Include Total Remittance from line 37 (at least $1,900)?
3. _____ Attach documentation for tax credits on lines 28, 29 and 30?
4. _____ Indicate your company's NAIC number on front of the tax form?
5. _____ Attach explanations for any unusual or extraordinary items?
6. _____ Fully complete Schedules D and E and attach them to this statement?

CO. NAME _____ NAIC # _____ STATE OF DOMICILE _____

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SCHEDULE D -- RETALIATORY SCHEDULE
ATTACHMENT TO 2005 ANNUAL PREMIUM TAX STATEMENT - FIRE & CASUALTY COMPANIES
STATE OF MONTANA

	(A) MONTANA	(B) STATE OF DOMICILE
1. Montana Net Premiums (from Schedule A, Line 5)		
2. Tax Rate	2.75%	
3. Premium Tax		
4. Certificate of Authority Continuation Fee per 33-2-708(1)(a), MCA	$1900.00	
5. Annual Statement Filing Fee	N/A	
6. Assessment for Insurance Department Operations	N/A	
7. Montana Fire Insurance Premium Tax (from Schedule B, Line 22)		N/A
8. Fire Marshal Tax	N/A	
9. Other Fire Taxes (explain)_____	N/A	
10. Other (explain)_____	N/A	
11. Other (explain)_____	N/A	
12. Total Montana Taxes & Fees (add lines 3 thru 7, col. A)		XXXXXXXXXXX
13. Total State of Domicile Taxes & Fees (add 3 thru 6, and 8 thru 11, col. B)	XXXXXXXXXXX	

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SCHEDULE E -- CALCULATION OF RETALIATORY TAX
ATTACHMENT TO 2005 ANNUAL PREMIUM TAX STATEMENT - FIRE & CASUALTY COMPANIES
STATE OF MONTANA

1. Enter Amount from Schedule D, Line 13, Col. B _____
2. Enter Amount from Schedule D, Line 12, Col. A _____
3. If Schedule E, Line 1 is larger than Schedule E, Line 2 enter difference on this line and transfer this amount to Schedule C, Line 24 _____
4. If Schedule E, Line 2 is larger than Schedule E, Line 1, enter $0 on this line and transfer $0 to Schedule C, Line 24 _____

6.6.2708 Application of Refund (1) If an insurer, on a form approved by the commissioner and under oath, notifies the commissioner that it is entitled to a refund, the commissioner may authorize a refund. An insurer is not entitled to receive interest on the refund.

MONTANA INSURANCE DEPARTMENT **840 HELENA AVENUE** **HELENA, MONTANA 59601** **(406) 444-2040**	**PREMIUM TAX REFUND REQUEST FORM** ***6.6.2708, ARM***

Insurer Name	**NAIC Number**

Mailing Address	**City**	**State**	**Zip Code**

State of Domicile	**Contact Person**	**Contact Person Telephone Number**

Reason for decrease in estimated premium tax liability for 2005.	**Method of calculation for refund.** **Calculation subject to audit by Department** A. 2005 Overpayment $_____ 2006 Pre-payment Requirement: B. 100% of 2005 Tax $_____ or C. 90% of 2006 Tax * $_____ **1. 2004 Overpayment $_____** **(A from above)** **2. Prepayment required $_____** **(B or C from above)** **3. Amount of Refund $_____** **(1 minus 2)** *** Please explain in left hand column.**

Title of Officer	**Name of Officer (Type or Print)**
Date	**Signature of Officer**

Subscribed and sworn to before me this_____day of _____, 20 _____.

_____(Notary Public)

Residing at _____

My commission expires _____

11/2005

Montana Insurance Department
840 Helena Avenue
Helena, MT 59601
(406) 444-2040

MONTANA MEDICAL MALPRACTICE PROFESSIONAL LIABILITY EXPERIENCE REPORT

Pursuant to 33-23-310, MCA

Supplement to _____ Annual Statement for _____ (Company)

To be filed March 1 (Surplus Lines - April 1).

REQUIRED INFORMATION - From preceding calendar year	**PHYSICIANS**	**OSTEOPATHS**	**PODIATRISTS**	**DENTISTS**	**OPTOMETRISTS**	**REGISTERED NURSE**	**LICENSED PRACTICAL NURSE**	**ALL OTHER SPECIALTIES**	**HEALTH CARE FACILITIES** as defined by 50-5-101(23), MCA	**TOTAL**
1. Number of insureds @ December 31										
a. Number of claims-made basis policies										
b. Number of occurrence basis policies										
2. a. Amount of direct premiums paid (written)										
b. Amount of direct premiums earned										
c. Total amount of underwriting expenses **(Note in Total column only)**	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
3. Number of claims made against insureds										
a. Direct losses paid in 3										
b. Direct Case loss reserves in 3										
c. Direct IBNR loss reserves in 3										
d. Direct ALAE paid in 3										
e. Direct Case ALAE reserves in 3										
f. Direct IBNR ALAE reserves in 3										
4. Number of closed claims with direct loss paid										
a. Total amount of direct losses paid in 4										
5. Number of claims open with no direct loss paid										
6. Number of lawsuits filed against insureds										
a. Number of lawsuit claims closed without settlement										
b. Number of lawsuit claims closed with settlement										
c. Total amount paid in settlements in 6b										
8. Number of lawsuits that went to trial										
a. Number of judgments or verdicts for the plaintiff in 8										
b. Number of judgments or verdicts for the insured in 8										
c. Number of other judgments of verdicts in 8										
9. Total of direct losses paid for claims that went to trial and were closed										

6.6.2707 Cessation of Business (1) If an insurer, on a form approved by the commissioner and under oath, notifies the commissioner that it is no longer writing new or renewing existing insurance policies of any type in the state, the commissioner may waive the periodic payment requirements established in these rules.

MONTANA INSURANCE DEPARTMENT **840 HELENA AVENUE** **HELENA, MONTANA 59601** **(406) 444-2040**	**CESSATION OF BUSINESS NOTIFICATION FORM** ***6.6.2707, ARM***

Insurer Name			**NAIC Number**
Mailing Address	**City**	**State**	**Zip Code**
State of Domicile	**Contact Person**	**Contact Person Telephone Number**	

Explanation of adjustment to quarterly tax pre-payment.

Title of Officer	**Name of Officer (Type or Print)**
Date	**Signature of Officer**

Subscribed and sworn to before me this_____day of _____, 20___.

_____(Notary Public)

Residing at _____

My commission expires _____

State of Montana

PROPERTY AND CASUALTY INSURERS
QUARTERLY PREMIUM TAX PAYMENT
DUE DATE: APRIL 15, 2006

Insurer Name:_____

NAIC #_____ Check Number:_____

QUARTERLY TAX PAYMENT CALCULATION:

Mail payment to:

Montana Ins. Dept.
840 Helena Ave.
Helena, MT 59601

1. '05 premium tax liability ***(#6 from tax return)*** or 90% of anticipated 2006 tax — $_____
2. Less allowable deductions ***(See instructions on reverse)*** — $(_____)
3. Total 2006 quarterly pre-payment ***(line #1 - #2)*** — $_____
4. Enter 25% of the amount on line #3 — $_____
5. Amount of 2005 overpayment applied to this payment ***(see line #38 of the tax return)*** — $(_____)
6. **QUARTERLY AMOUNT REMITTED** ***(#4 - #5)*** — **$**_____ ***(Instructions on Reverse)***

SAI-23 (11/05)

State of Montana

PROPERTY AND CASUALTY INSURERS
QUARTERLY PREMIUM TAX PAYMENT
DUE DATE: SEPTEMBER 15, 2006

Insurer Name:_____

NAIC #_____ Check Number:_____

QUARTERLY TAX PAYMENT CALCULATION:

Mail payment to:

Montana Ins. Dept.
840 Helena Ave.
Helena, MT 59601

1. '05 premium tax liability ***(#6 from tax return)*** or 90% of anticipated 2006 tax — $_____
2. Less allowable deductions ***(See instructions on reverse)*** — $(_____)
3. Total 2006 quarterly pre-payment ***(line #1 - #2)*** — $_____
4. Enter 25% of the amount on line #3 — $_____
5. Amount of 2005 overpayment applied to this payment ***(see line #38 of the tax return)*** — $(_____)
6. **QUARTERLY AMOUNT REMITTED** ***(#4 - #5)*** — **$**_____ ***(Instructions on Reverse)***

SAI-23 (11/05)

State of Montana

PROPERTY AND CASUALTY INSURERS
QUARTERLY PREMIUM TAX PAYMENT
DUE DATE: JUNE 15, 2006

Insurer Name:_____

NAIC #_____ Check Number:_____

QUARTERLY TAX PAYMENT CALCULATION:

Mail payment to:

Montana Ins. Dept.
840 Helena Ave.
Helena, MT 59601

1. '05 premium tax liability ***(#6 from tax return)*** or 90% of anticipated 2006 tax — $_____
2. Less allowable deductions ***(See instructions on reverse)*** — $(_____)
3. Total 2006 quarterly pre-payment ***(line #1 - #2)*** — $_____
4. Enter 25% of the amount on line #3 — $_____
5. Amount of 2005 overpayment applied to this payment ***(see line #38 of the tax return)*** — $(_____)
6. **QUARTERLY AMOUNT REMITTED** ***(#4 - #5)*** — **$**_____ ***(Instructions on Reverse)***

SAI-23 (11/05)

State of Montana

PROPERTY AND CASUALTY INSURERS
QUARTERLY PREMIUM TAX PAYMENT
DUE DATE: DECEMBER 15, 2006

Insurer Name:_____

NAIC #_____ Check Number:_____

QUARTERLY TAX PAYMENT CALCULATION:

Mail payment to:

Montana Ins. Dept.
840 Helena Ave.
Helena, MT 59601

1. '05 premium tax liability ***(#6 from tax return)*** or 90% if anticpated 2006 tax — $_____
2. Less allowable deductions ***(See instructions on reverse)*** — $(_____)
3. Total 2006 quarterly pre-payment ***(line #1 - #2)*** — $_____
4. Enter 25% of the amount on line #3 — $_____
5. Amount of 2005 overpayment applied to this payment ***(see line #38 of the tax return)*** — $(_____)
6. **QUARTERLY AMOUNT REMITTED** ***(#4 - #5)*** — **$**_____ ***(Instructions on Reverse)***

SAI-23 (11/05)

QUARTERLY TAX PAYMENT INSTRUCTIONS:

Line #2 Instructions:

The quarterly amounts should be reduced by subtracting the following **allowable deductions:**

A. Anticipated 2006 tax offsets (20% of Montana Life and Health Insurance Guaranty Association assessments paid during tax years 2001-05): $____________________

B. Montana Comprehensive Health Association assessments: $____________________
(excluding HIPAA Plan liability assessments)

Total allowable deductions to transfer to line #2 *(on front)*: **$____________________**

Other Instructions:

Do not combine amounts for affiliated companies on a single check.

If the amount on line #3 is zero or a negative amount: Enter zero on line #3 and #6 on all 4 payment vouchers and return all 4 vouchers to this office by April 15, 2006.

If insurer deems the total 2006 quarterly pre-payment requirement on line #3 to be a minimal amount (less than $100), combine all 4 payments in one check, complete all 4 vouchers and submit the payment on or before April 15, 2006.

If premium writings have declined from the previous year, you may substitute the amount on line #1 with an amount equaling 90% of the 2006 anticipated premium tax.

If you have any questions please contact our office at (406) 444-2040.

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